COLLEGE OF SOUTHERN IDAHO HEAD START/EARLY HEAD START
998 Washington St. N.
PO Box 1238
Twin Falls, Idaho 83303-1238
208-736-0741

Anticipatory Guidance for the 9 Month Well Child Physician Visit

Date_____

My baby is _____weeks old. He/she weighs _____

And is _____long and has a head circumference of _____.

At this visit you can expect:

- Your baby will be weighed and his or her length and head circumference will be measured.
- Your baby will be undressed for a full physical exam.
- Your baby's vision and hearing will be checked.
- Your baby's development will be checked.
- Your baby may have his or her blood checked for exposure to lead.
- Your baby may have a Hematocrit/hemoglobin tested for anemia.

Immunizations: Please provide Home Visitor with copies of completed immunizations and/or catch-up schedule. Ask your provider about these:

Hepatitis B-#3 (due at age 8 months up to 19 months)
Diphtheria, Tetanus Pertussis (DTaP)-#4 (due at age 8 months up to age 19 months)
Inactive Polio -#3 (due at age 8 months up to age 19 months)
Haemophilus influenza Type b (Hib)-#3 or 4
Pneumococcal-#4

You might want to discuss with your provider:

- Any illnesses your baby has experienced, any visits to another provider and any emergency room or side visits.
- Observations you have made about your baby's development and increasing independence.
- Teething concerns. Teaching your baby how to drink form a cup. Ask your provider to check your child's mouth for any cuts, sores, white spots, blisters of swelling of the gums. If teeth have erupted ask provider to check for white spots or cavities on teeth. If you have any concerns ask provider for a dental referral.
- Childproofing your home.
- Family changes since your last visit.
- How feeding is going. How to know when your baby is developmentally ready for additional foods. How recognize reactions to foods. What foods baby likes.
- Developmental Milestones: See CDC Chart.

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9-36 Month Nutritional Screening and Anticipatory Guidance

To be completed within 45 days of enrollment and following each age interval of: ***9, 12, 15, 18, 24, 30, and 36 months of age***

Office Use Only:	Enrollment Date:	FE Name:

Child's Name: _____

Date of Birth: _____ Parent/Guardian Names: _____

How many meals and snacks are offered to your child daily: _____ Meals _____ Snacks

Does your child:		**How often?**	**Comments**
Drink from a bottle	__ Yes __No	___times/day	_____
Drink from a cup	__ Yes __No	___times/day	_____
Take a bottle to bed	__ Yes __No	___times/day	_____

Does your child drink any of the following?

Breast milk	__Yes __ No	___times/day	_____
Formula	__Yes __ No	___times/day	type_____
Cows milk (pasteurized)	__Yes __ No	___times/day	1%,2%,whole_____
Evaporated milk	__Yes __ No	___times/day	_____
Soy or Rice Milk	__Yes __ No	___times/day	_____
Goats milk	__Yes __ No	___times/day	_____
Water	__Yes __ No	___times/day	_____
Juice	__Yes __ No	___times/day	_____
Tea	__Yes __ No	___times/day	_____
Kool-Aid/Soda	__Yes __ No	___times/day	_____
Cows milk (raw)	__Yes __ No	___times/day	_____

Does your child:		How Often?	Comments
Take vitamin or mineral supplements?	__Yes __ No	_____times/day	_____
Take herbal supplements?	__Yes __ No	_____times/day	_____
Take iron supplements?	__Yes __ No	_____times/day	_____
Eat non-food items?	__Yes __ No	_____times/day	_____

Are there any foods your child may not eat for personal, cultural, ethnic, religious, or health reasons?
__Yes __No *If yes, which ones*? _____
If yes, Please fill out a Food Preference form

Does your child have any special food or nutritional needs? __Yes __No
If yes, please explain: _____
If yes, Please fill out a Medical Food Substitution form

Child's Favorite Foods: _____
Child's Least Favorite Foods: _____
Are there any specific foods that you would like to see at Early Head Start Family Gatherings?
_____

Is your child on WIC?	__Yes __ No
Do your food dollars meet your family need?	__Yes __ No
Does your child live in a home that has running water?	__Yes __ No
Does your child live in a home that has a working stove and refrigerator?	__Yes __ No

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To be conducted at 9, 12, 15, 18, 24, 30, and 36 months of age

DAILY NUTRITIONAL INTAKE

Please write down everything that your child ate yesterday.
Was this a typical day? __Yes __ No

Time	Food/Drink Consumed	Amount Consumed (Cups, ounces, spoon-fuls, etc.)	Notes

Do you have any concerns about your child's eating patterns? __ Yes __ No
If yes, please explain? _____
_____
_____

If yes, Please send a copy of this form to the child's Primary Medical Provider

_____ _____
Parent/Guardian Signature **Date**

_____ _____
Staff Signature **Date**